State of Wisconsin
Office of the Commissioner of Insurance **December 2005**
With COSMOS Codes

Form Filing Checklist - Group Health

DISCLAIMER

The form filing checklists are intended only as guides for submitting various policy forms to the Office of the Commissioner of Insurance (OCI). The checklists are summaries, and are not intended as an OCI directive nor to interpret or address technical legal questions. Use of these checklists does not guarantee automatic approval of policy form submissions. Although efforts have been made to ensure that the checklists are current and accurate, information is subject to change on a regular basis without prior notice.

The cites in the second column reference Wisconsin statutes unless they begin with "Ins" which indicates an administrative code [regulation]

REQUIRED ITEMS FOR A COMPLETE FILING

Required	Reference	Comments
Filing Transmittal Form	601.42 (1) Ins 6.05	Submit separate form for each form substantially identical to Appendix B, s. Ins 6.05, Wis. Adm. Code
Cover Letter		Include a brief explanation of use and intent of the form filing, or that identifies amendments to prior policy form submissions
Certificate of Compliance	Ins 6.05	Substantially identical to Appendix A, s. Ins 6.05, Wis. Adm. Code, signed by an officer of the insurer
Certificate of Readability	Ins 6.07	Form that meets the minimum standards under s. Ins 6.07, Wis. Adm. Code, signed by an officer of the insurer
Rate Filing	Ins 3.14(3)	
Authorization to file on insurers behalf	Ins 6.03(3)(a)	

ALL GROUP HEALTH COVERAGES Product Category and Product Code: Group Accident & Health; Health Maintenance Organization (GAH, GDT, OTH, PHC, POS, VCO); Limited Service Health Organization (GCP, GDT, GMN, GVC, OTH); Preferred Provider Plan (GAH, GDT, PHC, POS, OTH, VCO).

Review Requirements	Reference	Comments
Face Page		
Corporate legal name	631.31, 631.64	Full corporate name on face page of policy, full address somewhere in policy
Important Notice	Ins 3.31(3)(a)	Notice required on front of certificate, concerning statements made in the application
Several liability	631.31 & 631.41	If two or more insurers together issue the policy
Claim methodology disclosure	Ins 3.60(5)	If insurer settles claim based on specific methodology, certificate must include notice on first page of certificate
Notice of right to file a complaint	631.28, Ins 6.85 (4)	Notice described under Appendix 1 or 2, s. Ins 6.85, Wis. Adm. Code.
General Contract		
Entire Contract	631.11	Representations, warranties, and conditions
Statement of Provisions	Ins 3.14(4)	Language required in certificate
Termination	631.36(4)& (5)& 632.79	60-day notice for certain nonrenewals, Prior notice of termination
Premium increase	631.36(5)	60-day notice of premium increases greater than 25%
Pre-existing condition limitations	632.745(23) & 632.746, Ins 3.31(3)	12 months or 18 months if late enrollee; If existence of pre-existing condition is disclosed on enrollment form, pre-existence defense cannot be used, unless condition is excluded from coverage by name or description

Incontestability	632.76	Policy is incontestable after 2 years, except for fraudulent misrepresentation
Grace period	632.78	Required grace period (7 day for weekly premium, 10 days for monthly, 31 days for all other policies)
Assignment and Change of Beneficiary	632.71	
Prohibited Provisions	632.75	
Permitted Provisions	632.77	
Change of Beneficiary and Related Provisions	Ins 3.30	
Restrictions on Health Care Services	632.87	Requires exclusion of health care practitioners
Definition of claim methodology	Ins 3.60(5)	Policy should disclose when percentile is 70% or less of UCR or RBRVS methodology
Notice and proof of loss	631.81	Notice or proof of loss is furnished as soon as reasonably possible & within one year of time required by policy
Limitation of actions	631.83(1)(b)	Action must be commenced w/in 3 years of when proof of loss was required to be furnished
Subrogation	Rimes	WI case law has established that the insurer's ability to recover is limited to the amount remaining after the insured has been made whole
Arbitration	631.85	
Mandatory Arbitration Prohibited	631.83(3)(c)	Policy may not provide that no action may be brought
Wisconsin Mandated Benefits		
No prior authorization for emergency room use	632.85	If the policy covers health care expenses, it may not require prior authorization for emergency room use
Coverage of drugs and devices	632.853	If the policy covers health care expenses and certain prescription drugs or devices, it shall develop an appeal process for which a physician can request an exception
Experimental treatment	632.855	If the policy covers health care expenses, and limits coverage of experimental treatment, it shall define the limitations in any agreement, policy, or certificate of coverage
Chiropractic services	632.87(3)	Coverage of services received from a chiropractor
Dentist services	632.87(4)	If the policy covers treatment of a condition by another health care provider, it may not exclude coverage for treatment of a condition by a licensed dentist within the scope of the dentist's license,
Nurse practitioner	632.87(5)	If the policy covers papanicolaou test, pelvic exams, and associated laboratory fees performed by a licensed physician, it must cover these services when performed by a nurse practitioner.
Complications of pregnancy	Ins 6.55(4)(b)(5)	Complications of pregnancy must be treated the same as any other illness or sickness under the policy
Handicapped children	632.88	Every hospital or medical expense policy that provides coverage for dependent children must provide an extension for handicapped children
HIPAA Requirements Maternity	632.746(2)	Pregnancy may not be considered a pre-existing condition [Does not apply to Accident, LSHOs, hospital or fixed indemnity, specified disease]
Eligibility		
Covered Individuals	632.896, 632.895 & 632.896	Adopted child, grand child, newborns [Does not apply to HIN, AON, ADD, DIN, SSA or TAC]
Handicapped Children	632.88	Hospital and medical expense policies
Continuation &/or COBRA	632.897	If the policy provides hospital and medical coverage, it must provide the right to continuation
Special Enrollment	632.746	Available in situations where other coverage has been lost either voluntarily or involuntarily [Does not apply to AON, ADD, LSHOs, HIN, SPD]

Form Filing Checklist – Group Health

December 2005

REQUIREMENTS FOR GROUP HEALTH PLANS (defined as disability insurance policy under s. 632.895 (1) (a), Wis. Stat.) Product Category and Product Code: Group Accident & Health (ALL, BKT, CAN, DTl, OTH, HSM, MAM, PHC, SPD, SSM, VOC); Health Maintenance Organization (GAH, GDT); Limited Service Health Organization (GCP, GDT, GMN, GVC); Preferred Provider Plan (GAH, GDT, PHC, POS, OTH, VCO). [Does not apply to HIN, AON, ADD, DIN, SSA or TAC]

Review Requirements	Reference	Comments
Additional Mandated Benefits		
Home health care	632.895(1) (2)	If the policy covers expenses incurred for inpatient hospital expenses, it must cover a minimum of 40 home care visits per contract year
Skilled nursing care	632.895(3)	If the policy provides coverage for hospital care, it must provide for 30 days of coverage per skilled nursing home confinement
Kidney disease treatment	632.895(4)	If the policy provides hospital treatment coverage, it must provide a $30,000 annual kidney disease benefit (i.e., dialysis, transplantation, donor related services)
Newborn coverage	632.895(5) and Ins 3.38	Coverage of newborn of insured from moment of birth
Congenital Defects & Birth Abnormalities	632.895(5)	Policies must treat as accident or sickness and cover function repair or restoration
Grandchildren coverage	632.895(5m)	If the policy provides coverage for any child of the insured, it must provide the same coverage for all children of that child until that child is 18 years of age
Diabetic coverage	632.895(6)	If the policy provides coverage for diabetes, it must cover installation and use of infusion pump, all other equipment and supplies for diabetes, including insulin
Maternity coverage	632.895(7)	If the policy provides maternity coverage, it must provide maternity coverage for all persons covered under the policy
Temporomandibular disorder (TMJ or TMD)	632.895(11)	If the policy provides coverage for diagnostic and surgical procedures for treatment of bone, joint, muscle or tissue, it must cover TMJ [Does not apply to policies that only cover dental care]
Facility charges and anesthetics for certain dental care	632.895(12)	Coverage of charges and anesthetics provided in conjunction with dental care for children under age 5, individual with disability, or individual with medical condition that requires hospitalization or anesthesia for dental care [Does not apply to policies that only cover dental care]
Breast reconstruction	632.895(13)	If the policy provides coverage of a mastectomy, it must provide coverage or breast reconstruction of the affected tissue incident to a mastectomy
Immunizations	632.895(14)	If the policy provides coverage for the dependent of an insured, it must provide coverage of appropriate and necessary immunizations for dependent children from birth to age 6 [Does not apply to SPD, hospital or surgical policies, or LSHOs]
Adopted children	632.896	If the policy provides coverage for dependent children, it must provide coverage for adopted children or children placed for adoption with the insured
Mammograms	632.895(8)	If the policy provides coverage for women over age 45, it must cover 2 mammograms for women age 45-49, annual mammograms for women 50 or older [Does not apply to SPD or LSHO]
HIV drugs	632.895(9)	If the policy provides coverage of prescription medication, it must provide coverage of drugs for the treatment of HIV [Does not apply to SPD or LSHO]
Lead poisoning screening	632.895(10)	Coverage for blood lead test for children under 6 years of age [Does not apply to SPD or LSHO]
Mental & Nervous Disorders & AODA	632.89 & Ins 3.37(5)	Policy must provide in-patient, out-patient, and transitional treatment for alcoholism, drug abuse, and mental/nervous disorders. Policy form must indicate types of transitional treatment programs and services covered.

ADDITIONAL REQUIREMENTS FOR GROUP HEALTH INSURANCE Product Category and Product Code: Group Accident & Health (ADD, BKT, OTH, HIN, HSM, MAM, SPD, SSM); Health Maintenance Organization (GAH, GDT, PHC, POS, VCO); Limited Service Health Organization (GCP, GDT, GMN, GVC); (Preferred Provider Plan (GAH, GDT, PHC, POS, VCO).

Review Requirements	Reference	Comments
Internal Grievance Procedure	632.85, subchs II, ch. Ins 18	BULLETIN April 26, 2002 http://oci.wi.gov/bulletin/0402iro.htm
Independent Review Procedure	632.835, subchs III, ch. Ins 18	BULLETIN April 26, 2002 http://oci.wi.gov/bulletin/0402iro.htm [Does not include LSHO]

ADDITIONAL REQUIREMENTS FOR SMALL EMPLOYER PLANS

Review Requirements	Reference	Comments
Small Employer Requirements		BULLETIN October 2, 1997 http://oci.wi.gov/bulletin/1097bul.htm#smallemp
Definition of small employer	635.02	2-50 employees;
Participation requirements	Ins 8.46	Establishes participation requirements an insurer may impose on a group.
Non-renewal or termination based on participation requirements	Ins 8.54 (4)	Insurer must give policyholder an additional 60 days to increase participation to required number.

REQUIREMENTS FOR DEFINED NETWORK PLANS, LIMITED SERVICE HEALTH ORGANIZATIONS OR PREFERRED PROVIDER PLANS (that are defined network plans) Product Category: Health Maintenance Organization (HMO), Limited Service Health Organization (LSHO), Preferred Provider Plan (PPP)

Review Requirements	Reference	Comments
HMO & PSO joint filing	631.41	Policy jointly may be issued jointly
Disclosure of Restrictions	Ins 9.38(2)	Emergency & urgent care, primary & urgent provider, changing provides, out-of-pocket costs, dependents not residing in service area
Definitions		
Managed Care Definitions	Ins 9.38(1)	Geographic Service Area, Emergency Care, Urgent Care, Out-of-Area Service, Dependent, Primary Provider
Enrollee	609.01(1d)	
Participating Provider	609.01(3m)	
Primary Care Physician & Primary Provider	609.01(4m) & (5)	
Benefit Description		
Designation of Primary Provider	609.05(2)	May require designation of primary provider and referral to another participating provider
No referrals for Ob/Gyn Services	609.22(4m) (2)	If policy provides coverage of obstetric or gynecologic services, it may not require referral for OB/Gyn services and must include written statement in policy or certificate [Does not apply to LSHO]
Referrals	609.05(3)	Requirements for obtaining referral from PCP
Standing Referral	609.22(4), Ins 9.38(4)(a).	If policy requires referral [Does not apply to LSHO]
2nd Opinion	609.22(5), Ins 9.38(4)(b)	Positive statement regarding 2nd opinion from participating provider [Does not apply to LSHO]
Emergency & Urgent Care	609.22(6), Ins 9.38(4)(c)	May require notification, but not less than 48 hours after receiving services [Does not apply to LSHO]
Continuity of care	609.24	Provision regarding continuity of care for provider that has left the plan [Does not apply to LSHO]

Out-of-Pocket Expenses	Ins 9.38(2)(d)	Description of restricted network provisions, including coinsurance and deductibles when non-network providers are utilized
Court Ordered Mental Health Services	609.65	
Dependent Student	609.655	Coverage of outpatient nervous and mental disorders if student attending school located within state but outside geographic service area, if services would be covered within geographic service area [Does not apply to LSHO]
Disclosure of Mandated Benefits	Ins 9.38(3)	Disclosure of all benefits mandated by Wisconsin Statutes
Disclosure of Procedures	Ins 9.38(4)	Referral, second opinion, notification of emergency room usage
Disenrollment	Ins 9.39	Applies to HMOs & LSHOs
Quality Assurance Plan	Ins 9.40(7)	Description and statement of patient rights & responsibilities in certificate or enrollment materials

REQUIREMENTS FOR PREFERRED PROVIDER PLANS [that are not defined network plans] Product Category: Preferred Provider Plan (PPP)

Review Requirements	Reference	Comments
Benefit Description		
Differential between PPO and Non-PPO Providers	631.20	May not be more than 30%
Primary Provider Selection	609.22(3)	PPPs may not require selection of primary provider
Referrals	609.05(3)	PPPs may not require referrals
Standing Referral	609.22(4), Ins 9.38(4)(a).	PPPs may not require referrals
Immunizations	632.895(14)	Does not apply to PPPs that are not defined network plans

APPLICATION & ENROLLMENT FORM REQUIREMENTS Product Category and Product Code: Group Accident & Health; Health Maintenance Organization (GAH, GDT, OTH, PHC, POS, VCO); Limited Service Health Organization (GCP, GDT, GMN, GVC, OTH); Preferred Provider Plan (GAH, GDT, PHC, POS, OTH, VCO).

Review Requirements	Reference	Comments
Certificate of Compliance	Ins 6.05	Signed by officer of the insurance company (When application is filed as separate submission)
Readability	Ins 3.13(4)(c)	10-point type
Corporate Name	631.20(2)	Include legal name of company on application
No Misleading Language	631.20(2)	Complex language or vagueness
Replacement	Ins 3.29(5)	Yes/No question
General Health Questions	631.20(2)	Hospitalizations, surgeries or tests must be scheduled or completed
Genetic Testing	631.89	No questions regarding genetic testing & no requirement for testing
Enrollment Forms		
Requirements	Ins 3.31(3)(a)1	
Small Employer Uniform Employee Application	635.10 & Ins 8.49	BULLETIN September 3, 2003 http://oci.wi.gov/bulletin/0903smap.htm
Personal medical information disclosure authorization	610.70(2)	If form authorizes disclosure of personal medical information, specific information must be included in disclosure authorization